AMENDED IN SENATE AUGUST 20, 2012

AMENDED IN ASSEMBLY APRIL 17, 2012

AMENDED IN ASSEMBLY MARCH 29, 2012

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 1453

Introduced by Assembly Member Monning

January 5, 2012

~~An act to add Section 1367.005 to the Health and Safety Code, and to add Section 10112.27 to the Insurance Code, relating to health care coverage.~~ *An act to add Section 1367.005 to the Health and Safety Code, and to add Section 10112.27 to the Insurance Code, relating to health care coverage.*

LEGISLATIVE COUNSEL'S DIGEST

AB 1453, as amended, Monning. ~~Essential health benefits.~~ *Health care coverage: essential health benefits.*

Commencing January 1, 2014, existing law, the federal Patient Protection and Affordable Care Act (PPACA), requires a health insurance issuer that offers coverage in the small group or individual market to ensure that such coverage includes the essential health benefits package, as defined. PPACA requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers. PPACA defines a qualified health plan as a plan that, among other requirements, provides an essential health benefits package. Existing state law creates the California Health Benefit Exchange (the Exchange) to facilitate the purchase of qualified health

plans by qualified individuals and qualified small employers by January 1, 2014.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contracts and health insurance policies to cover various benefits.

This bill would require an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2014, to cover essential health benefits, which would be defined to include the health benefits covered by particular benchmark plans. The bill would authorize a plan or insurer to place scope and duration limits on those benefits, except as specified, provided that the limits are not greater than the limits imposed by the benchmark plans and would generally prohibit a plan or insurer from making substitutions of the benefits required to be covered. The bill would specify that these provisions apply regardless of whether the contract or policy is offered inside or outside the Exchange but would provide that they do not apply to grandfathered plans or plans that cover only excepted benefits, as specified. The bill would prohibit a health care service plan or health insurer, when offering, selling, or marketing a plan contract or policy, from indicating or implying that the contract or policy covers essential health benefits unless the contract or policy covers essential health benefits as provided in the bill. The bill would enact other related provisions.

These provisions would only be implemented to the extent essential health benefits are required pursuant to PPACA.

Because a willful violation of the bill's provisions with respect to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

~~Commencing January 1, 2014, existing law, the federal Patient Protection and Affordable Care Act (PPACA), requires a health~~

~~insurance issuer that offers coverage in the small group or individual market to ensure that such coverage includes the essential health benefits package, as defined. PPACA requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers. PPACA defines a qualified health plan as a plan that, among other requirements, provides the essential health benefits package. Existing state law creates the California Health Benefit Exchange (the Exchange) to facilitate the purchase of qualified health plans by qualified individuals and qualified small employers by January 1, 2014.~~

~~Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contracts and health insurance policies to cover various benefits.~~

~~This bill would require an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2014, to cover essential health benefits, which would be defined to include the benefits and services covered by particular plans. The bill would specify that this provision applies regardless of whether the contract or policy is offered inside or outside the Exchange but would provide that it does not apply to grandfathered plans or plans that offer excepted benefits, as specified. The bill would prohibit a health care service plan or health insurer, when offering, issuing, selling, or marketing a plan contract or policy, from indicating or implying that the contract or policy covers essential health benefits unless the contract or policy covers essential health benefits as provided in the bill.~~

~~Because a willful violation of the bill's provisions with respect to health care service plans would be a crime, the bill would impose a state-mandated local program.~~

~~The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.~~

~~This bill would provide that no reimbursement is required by this act for a specified reason.~~

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. The Legislature hereby finds and declares the following:

(a) Commencing January 1, 2014, the federal Patient Protection and Affordable Care Act (PPACA) requires a health insurance issuer that offers coverage to small employers or individuals, both inside and outside of the California Health Benefit Exchange, with the exception of grandfathered plans as defined under Section 1251 of PPACA, to provide minimum coverage that includes essential health benefits, as defined.

(b) It is the intent of the Legislature to comply with federal law and consistently implement the essential health benefits provisions of PPACA and related federal guidance and regulations, by adopting the uniform minimum essential benefits requirement in state-regulated health care coverage regardless of whether the policy or contract is regulated by the Department of Managed Health Care or the Department of Insurance and regardless of whether the policy or contract is offered to individuals or small employers inside or outside of the California Health Benefit Exchange.

SEC. 2. Section 1367.005 is added to the Health and Safety Code, to read:

1367.005. (a) An individual or small group health care service plan contract issued, amended, or renewed on or after January 1, 2014, shall, at a minimum, include coverage for essential health benefits. For purposes of this section, "essential health benefits" means all of the following:

(1) (A) The health benefits covered by the Kaiser Foundation Health Plan Small Group HMO 30 plan (federal health product identification number 40513CA035) as this plan was offered during the first quarter of 2012, including, but not limited to, all of the following:

(i) The health benefits covered by the plan within the categories identified in subsection (b) of Section 1302 of PPACA, including, but not limited to, ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and

substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.

(ii) The health benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, including, but not limited to, basic health care services required to be covered pursuant to Section 1367, as defined in Section 1345 and in Section 1300.67 of Title 28 of the California Code of Regulations. These benefits are required to be covered to the extent described in the following sections: Sections 1367.002, 1367.06, and 1367.35 (preventive services for children); Section 1367.25 (prescription drug coverage for contraceptives); Section 1367.45 (AIDS vaccine); Section 1367.46 (HIV testing); Section 1367.51 (diabetes); Section 1367.54 (alpha feto protein testing); Section 1367.6 (breast cancer screening); Section 1367.61 (prosthetics for laryngectomy); Section 1367.62 (maternity hospital stay); Section 1367.63 (reconstructive surgery); Section 1367.635 (mastectomies); Section 1367.64 (prostate cancer); Section 1367.65 (mammography); Section 1367.66 (cervical cancer); Section 1367.665 (cancer screening tests); Section 1367.67 (osteoporosis); Section 1367.68 (surgical procedures for jaw bones); Section 1367.71 (anesthesia for dental); Section 1367.9 (conditions attributable to diethylstilbestrol); Section 1368.2 (hospice care); Section 1370.6 (cancer clinical trials); Section 1371.5 (emergency response ambulance or ambulance transport services); subdivision (b) of Section 1373 (sterilization operations or procedures); Section 1373.4 (inpatient hospital and ambulatory maternity); Section 1374.56 (phenylketonuria); Section 1374.17 (organ transplants for HIV); Section 1374.72 (mental health parity); and Section 1374.73 (autism/behavioral health treatment).

(iii) The health benefits covered by the plan that are not otherwise required to be covered under this chapter, to the extent required pursuant to Sections 1367.18, 1367.21, 1367.215, 1367.22, 1367.24, and 1367.25, and Section 1300.67.24 of Title 28 of the California Code of Regulations, whether or not the health benefits are specifically referenced in the plan contract.

(B) Coverage of mental health and substance use disorder services pursuant to this paragraph, along with any scope and

duration limits imposed on the benefits, shall be in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343), and all binding rules, regulations, or guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

(2) With respect to habilitative services, in addition to any habilitative services identified in paragraph (1), coverage shall also be provided as required by binding federal rules, regulations, and guidance issued pursuant to Section 1302(b) of PPACA. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the plan contract.

(3) With respect to pediatric vision care, the same health benefits for pediatric vision care covered under the Federal Employees Dental and Vision Insurance Program vision plan with the largest national enrollment as of the first quarter of 2012. The pediatric vision care benefits covered pursuant to this paragraph shall be in addition to, and shall not replace, any vision services covered under the plan identified in paragraph (1).

(4) With respect to pediatric oral care, the same health benefits for pediatric oral care covered under the dental plan available to subscribers of the Healthy Families Program in 2011–12, including the provision of medically necessary orthodontic care provided pursuant to the federal Children's Health Insurance Program Reauthorization Act of 2009. The pediatric oral care benefits covered pursuant to this paragraph shall be in addition to, and shall not replace, any dental or orthodontic services covered under the plan identified in paragraph (1).

(5) Except as otherwise provided in subdivision (p), any other benefits required to be covered under this chapter.

(b) (1) Medically necessary health benefits described in this section shall be covered subject to cost sharing approved by the director and any limitations consistent with this section. Limitations imposed on health benefits shall be no greater than the limitations imposed by the corresponding plans identified in subdivision (a).

(2) A plan may place scope and duration limits on health benefits described in this section, other than basic health care services described in clause (ii) of subparagraph (A) of paragraph (1) of subdivision (a), provided that the scope and duration limits

are no greater than the scope and duration limits imposed on those benefits by the corresponding plans identified in subdivision (a).

(c) Except as otherwise provided in subdivision (d), if it is determined that a plan identified in subdivision (a), with respect to benefits and services covered by a plan contract and any scope and duration limits applied to those benefits and services pursuant to the contract, is not fully in compliance with this chapter, the identification of that plan pursuant to this section shall not be construed to exempt the plan from full compliance with this chapter.

(d) Notwithstanding subdivision (c) or any other provision of this section, the home health services benefits covered under the plan identified in paragraph (1) of subdivision (a) shall be deemed to not be in conflict with this chapter.

(e) Except as provided in subdivision (f), nothing in this section shall be construed to permit a health care service plan to make substitutions for the benefits required to be covered under this section, regardless of whether those substitutions are actuarially equivalent.

(f) To the extent permitted under Section 1302 of PPACA and any binding rules, regulations, or guidance issued pursuant to that section, and to the extent that substitution would not create an obligation for the state to defray costs for any individual, a plan may substitute its prescription drug formulary for the formulary provided under the plan identified in subdivision (a) as long as the formulary complies with the sections referenced in clauses (ii) and (iii) of subparagraph (A) of paragraph (1) of subdivision (a) that apply to prescription drugs.

(g) No health care service plan, or its agent, solicitor, or representative, shall offer, market, represent, or sell any product, contract, or discount arrangement as minimum coverage, or as compliant with the essential health benefits requirement in federal law, unless it meets all of the requirements of this section.

(h) This section shall apply regardless of whether the plan contract is offered inside or outside the California Health Benefit Exchange created by Section 100500 of the Government Code.

(i) A plan contract subject to this section shall comply with Section 1367.001.

(j) A plan contract subject to this section shall comply with state and federal statutory and regulatory requirements regarding nondiscrimination, including, but not limited to, Section 1365.5.

(k) This section shall not be construed to prohibit a plan contract from covering additional benefits, including, but not limited to, spiritual care services that are tax deductible under Section 213 of the Internal Revenue Code.

(l) Subdivision (a) shall not apply to any of the following:

(1) A specialized health care service plan contract.

(2) A Medicare supplement plan.

(3) A plan contract that qualifies as a grandfathered health plan under Section 1251 of PPACA or any binding rules, regulations, or guidance issued pursuant to that section.

(m) Nothing in this section shall be implemented in a manner that is inconsistent with, or conflicts with, a requirement of PPACA.

(n) This section shall be implemented only to the extent essential health benefits are required pursuant to PPACA.

(o) An essential health benefit is required to be provided under this section only to the extent that federal law or policy does not require the state to defray the costs of the benefit.

(p) A plan is not required to cover, under this section, changes to health benefits that are the result of statutes enacted on or after December 31, 2011.

(q) No later than February 1, 2013, the director shall, in consultation with the Insurance Commissioner, develop and publish a list of covered health benefits and limitations contained in the plans subject to this section, to ensure consistency and uniformity between health care service plan contracts and health insurance policies. In developing the list, the director and commissioner shall take into account federal statutes, rules, regulations, and guidance applicable to essential health benefits as of that date. Development and publication of the list is not subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(r) (1) Notwithstanding the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the department, until March 1, 2016, may implement and administer this section through all-plan letters or similar instruction from the department until regulations are adopted.

(2) The department may adopt emergency regulations implementing this section. The department may, on a one-time basis, readopt any emergency regulation authorized by this section that is the same as, or substantially equivalent to, an emergency regulation previously adopted under this section.

(3) The initial adoption of emergency regulations implementing this section and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. Initial emergency regulations and the readoption of emergency regulations authorized by this section shall be exempt from review by the Office of Administrative Law. The initial emergency regulations and the readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(4) The director shall consult with the Insurance Commissioner to ensure consistency and uniformity in the development of all-plan letters and regulations.

(s) For purposes of this section, the following definitions shall apply:

(1) "Habilitative services" means health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health deficit or health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment. Habilitation services do not include respite, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including, but not limited to, vocational training. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the plan contract.

(2) (A) "Health benefits," unless otherwise required to be defined pursuant to binding federal rules, regulations, or guidance issued pursuant to Section 1302(b) of PPACA, means health care items or services for the diagnosis, cure, mitigation, treatment, or prevention of illness, injury, disease, or a health condition, including a mental health condition.

(B) "Health benefits" does not mean any cost-sharing requirements or limitations such as copayments, coinsurance, or deductibles.

(3) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(4) "Small group health care service plan contract" means a group health care service plan contract issued to a small employer, as defined in Section 1357.

SEC. 3. Section 10112.27 is added to the Insurance Code, to read:

10112.27. (a) An individual or small group health insurance policy marketed, offered, sold, issued, delivered, or renewed on or after January 1, 2014, shall, at a minimum, include coverage for essential health benefits. For purposes of this section, "essential health benefits" means all of the following:

(1) (A) The health benefits covered by the Kaiser Foundation Health Plan Small Group HMO 30 plan (federal health product identification number 40513CA035) as this plan was offered during the first quarter of 2012, including, but not limited to, all of the following:

(i) The health benefits covered by the plan within the categories identified in subsection (b) of Section 1302 of PPACA, including, but not limited to, ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.

(ii) The health benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, including, but not limited to, basic health care services required to be covered pursuant to Section 1367, as defined in Section 1345 of the Health and Safety Code, and in Section 1300.67 of Title 28 of the California Code of Regulations. These benefits are required to be covered to the extent described in the following sections of the Health and Safety Code: Sections 1367.002, 1367.06, and 1367.35

(preventive services for children); Section 1367.25 (prescription drug coverage for contraceptives); Section 1367.45 (AIDS vaccine); Section 1367.46 (HIV testing); Section 1367.51 (diabetes); Section 1367.54 (alpha feto protein testing); Section 1367.6 (breast cancer screening); Section 1367.61 (prosthetics for laryngectomy); Section 1367.62 (maternity hospital stay); Section 1367.63 (reconstructive surgery); Section 1367.635 (mastectomies); Section 1367.64 (prostate cancer); Section 1367.65 (mammography); Section 1367.66 (cervical cancer); Section 1367.665 (cancer screening tests); Section 1367.67 (osteoporosis); Section 1367.68 (surgical procedures for jaw bones); Section 1367.71 (anesthesia for dental); Section 1367.9 (conditions attributable to diethylstilbestrol); Section 1368.2 (hospice care); Section 1370.6 (cancer clinical trials); Section 1371.5 (emergency response ambulance or ambulance transport services); Subdivision (b) of Section 1373 (sterilization operations or procedures); Section 1373.4 (inpatient hospital and ambulatory maternity); Section 1374.56 (phenylketonuria); Section 1374.17 (organ transplants for HIV); Section 1374.72 (mental health parity); and Section 1374.73 (autism/behavioral health treatment).

(iii) The health benefits covered by the plan that are not otherwise required to be covered under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, to the extent otherwise required pursuant to Sections 1367.18, 1367.21, 1367.215, 1367.22, 1367.24, and 1367.25 of the Health and Safety Code, and Section 1300.67.24 of Title 28 of the California Code of Regulations, whether or not the health benefits are specifically referenced in the health insurance policy.

(B) Coverage of mental health and substance use disorder services pursuant to this paragraph, along with any scope and duration limits imposed on the benefits, shall be in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343), and all binding rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

(2) With respect to habilitative services, in addition to any habilitative services identified in paragraph (1), coverage shall also be provided as required by binding federal rules, regulations, or guidance issued pursuant to Section 1302(b) of PPACA.

Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the policy.

(3) With respect to pediatric vision care, the same health benefits for pediatric vision care covered under the Federal Employees Dental and Vision Insurance Program vision plan with the largest national enrollment as of the first quarter of 2012. The pediatric vision care services covered pursuant to this paragraph shall be in addition to, and shall not replace, any vision services covered under the plan identified in paragraph (1).

(4) With respect to pediatric oral care, the same health benefits for pediatric oral care covered under the dental plan available to subscribers of the Healthy Families Program in 2011–12, including the provision of medically necessary orthodontic care provided pursuant to the federal Children's Health Insurance Program Reauthorization Act of 2009. The pediatric oral care benefits covered pursuant to this paragraph shall be in addition to, and shall not replace, any dental or orthodontic services covered under the plan identified in paragraph (1).

(5) Except as otherwise provided in subdivision (p), any other benefits required to be covered under this part.

(b) (1) Medically necessary health benefits described in this section shall be covered subject to cost sharing approved by the commissioner and any limitations consistent with this section. Limitations imposed on health benefits shall be no greater than the limitations imposed by the corresponding plans identified in subdivision (a).

(2) A plan may place scope and duration limits on health benefits described in this section, other than basic health care services described in clause (ii) of subparagraph (A) of paragraph (1) of subdivision (a), provided that the scope and duration limits are no greater than the scope and duration limits imposed on those benefits by the corresponding plans identified in subdivision (a).

(c) Except as otherwise provided in subdivision (d), if it is determined that a plan identified in subdivision (a), with respect to benefits and services covered by a policy and any scope and duration limits applied to those benefits and services pursuant to the policy, is not fully in compliance with this part, the identification of that plan pursuant to this section shall not be construed to exempt the plan from full compliance with this part.

(d) Notwithstanding subdivision (c) or any other provision of this section, the home health services benefits covered under the plan identified in paragraph (1) of subdivision (a) shall be deemed to not be in conflict with this part.

(e) Except as provided in subdivision (f), nothing in this section shall be construed to permit a health insurer to make substitutions for the benefits required to be covered under this section, regardless of whether those substitutions are actuarially equivalent.

(f) To the extent permitted under Section 1302 of PPACA and any binding rules, regulations, or guidance issued pursuant to that section, and to the extent that substitution would not create an obligation for the state to defray costs for any individual, an insurer may substitute its prescription drug formulary for the formulary provided under the plan identified in subdivision (a) as long as the formulary complies with the sections referenced in clauses (ii) and (iii) of subparagraph (A) of paragraph (1) of subdivision (a) that apply to prescription drugs.

(g) No health insurer, or its agent, producer, or representative, shall offer, market, represent, or sell any product, policy, or discount arrangement as minimum coverage, or as compliant with the essential health benefits requirement in federal law, unless it meets all of the requirements of this section.

(h) This section shall apply regardless of whether the policy is offered inside or outside the California Health Benefit Exchange created by Section 100500 of the Government Code.

(i) A health insurance policy subject to this section shall comply with Section 10112.1.

(j) A health insurance policy subject to this section shall comply with state and federal statutory and regulatory requirements regarding nondiscrimination, including, but not limited to, Section 10140.

(k) This section shall not be construed to prohibit a policy from covering additional benefits, including, but not limited to, spiritual care services that are tax deductible under Section 213 of the Internal Revenue Code.

(l) Subdivision (a) shall not apply to any of the following:

(1) A policy consisting solely of coverage of excepted benefits as described in Sections 2722 and 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-21; 42 U.S.C. Sec. 300gg-91).

(2) A policy that qualifies as a grandfathered health plan under Section 1251 of PPACA or any binding rules, regulation, or guidance issued pursuant to that section.

(m) Nothing in this section shall be implemented in a manner that is inconsistent with, or conflicts with, a requirement of PPACA.

(n) This section shall be implemented only to the extent essential health benefits are required pursuant to PPACA.

(o) An essential health benefit is required to be provided under this section only to the extent that federal law or policy does not require the state to defray the costs of the benefit.

(p) An insurer is not required to cover, under this section, changes to health benefits that are the result of statutes enacted on or after December 31, 2011.

(q) No later than February 1, 2013, the commissioner shall, in consultation with the Director of the Department of Managed Health Care, develop and publish a list of covered health benefits and limitations contained in the health insurance policies subject to this section, to ensure consistency and uniformity between health insurance policies and health care service plan contracts. In developing the list, the commissioner and director shall take into account federal statutes, rules, regulations, and guidance applicable to essential health benefits as of that date. Development and publication of the list is not subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(r) (1) Notwithstanding the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the commissioner, until March 1, 2016, may implement and administer this section through insurer letters or similar instruction from the commissioner until regulations are adopted.

(2) The commissioner may adopt emergency regulations implementing this section. The commissioner may, on a one-time basis, readopt any emergency regulation authorized by this section that is the same as, or substantially equivalent to, an emergency regulation previously adopted under this section.

(3) The initial adoption of emergency regulations implementing this section and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace,

health, safety, or general welfare. Initial emergency regulations and the readoption of emergency regulations authorized by this section shall be exempt from review by the Office of Administrative Law. The initial emergency regulations and the readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(4) The commissioner shall consult with the Director of the Department of Managed Health Care to ensure consistency and uniformity in the development of insurer letters and regulations.

(s) Nothing in this section shall impose on health insurance policies the cost sharing or network limitations of the plans identified in subdivision (a) except to the extent otherwise required to comply with provisions of this code, including this section, and as otherwise applicable to all health insurance policies offered to individuals and small groups.

(t) For purposes of this section, the following definitions shall apply:

(1) "Habilitative services" means health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health deficit or health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment. Habilitation services do not include respite, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including, but not limited to, vocational training. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the policy.

(2) (A) "Health benefits," unless otherwise required to be defined pursuant to binding federal rules, regulations, or guidance issued pursuant to Section 1302(b) of PPACA, means health care items or services for the diagnosis, cure, mitigation, treatment, or prevention of illness, injury, disease, or a health condition, including a mental health condition.

(B) "Health benefits" does not mean any cost-sharing requirements or limitations such as copayments, coinsurance, or deductibles.

(3) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(4) "Small group health insurance policy" means a group health care service insurance policy issued to a small employer, as defined in Section 10700.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

~~SECTION 1. The Legislature hereby finds and declares the following:~~

~~(a) Commencing January 1, 2014, the federal Patient Protection and Affordable Care Act (PPACA) requires a health insurance issuer that offers coverage to small employers or individuals, both inside and outside of an American Health Benefit Exchange, with the exception of grandfathered plans, to provide minimum coverage that includes essential health benefits, as defined.~~

~~(b) It is the intent of the Legislature to comply with federal law and consistently implement the essential health benefits provisions of PPACA and related federal guidance and regulations, by adopting the uniform minimum essential benefits requirement in state-regulated health care coverage regardless of whether the policy or contract is regulated by the Department of Managed Health Care or the Department of Insurance and regardless of whether the policy or contract is offered to individuals or small employers inside or outside of the California Health Benefit Exchange.~~

~~SEC. 2. Section 1367.005 is added to the Health and Safety Code, to read:~~

~~1367.005. (a) An individual or small group health care service plan contract issued, amended, or renewed on or after January 1, 2014, shall, at a minimum, include coverage for essential health~~

~~benefits. For purposes of this section, "essential health benefits" means all of the following:~~

~~(1) (A) The benefits and services covered by the Kaiser Small Group HMO plan contract (product number 40513CA035) as this contract was offered during the first quarter of 2012, including, but not limited to, all of the following:~~

~~(i) The items and services covered by the plan contract within the categories identified in subsection (b) of Section 1302 of PPACA, including, but not limited to, ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric vision care.~~

~~(ii) Mandated benefits pursuant to statutes enacted before December 31, 2011.~~

~~(B) The services and benefits described in this paragraph shall be covered to the extent they are medically necessary. Scope and duration limits imposed on the services and benefits described in this paragraph shall be no greater than the scope and duration limits imposed on those services and benefits by the plan contract identified in subparagraph (A).~~

~~(2) With respect to habilitative services, in addition to any habilitative services identified in paragraph (1), the same services as the plan contract covers for rehabilitative services. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the plan contract.~~

~~(3) With respect to pediatric oral care and pediatric vision care, the same services and benefits for pediatric oral care and pediatric vision care covered under the Federal Employees Dental and Vision Insurance Program dental plan and vision plan with the largest national enrollment as of the first quarter of 2012. Scope and duration limits imposed on the services and benefits described in this paragraph shall be no greater than the scope and duration limitations imposed on those benefits by the Federal Employees Dental and Vision Insurance Program dental plan and vision plan with the largest national enrollment as of the first quarter of 2012.~~

~~(4) Any other benefits required to be covered under this chapter.~~

~~(b) When offering, issuing, selling, or marketing a health care service plan contract, a health care service plan shall not indicate or imply that the plan contract covers essential health benefits unless the plan contract covers essential health benefits as defined in this section.~~

~~(c) This section shall apply regardless of whether the plan contract is offered inside or outside the California Health Benefit Exchange created by Section 100500 of the Government Code.~~

~~(d) A plan contract subject to this section shall also comply with Section 1367.001.~~

~~(e) This section shall not be construed to prohibit a plan contract from covering additional benefits, including, but not limited to, spiritual care services that are tax deductible under Section 213 of the Internal Revenue Code.~~

~~(f) Subdivision (a) shall not apply to any of the following:~~

~~(1) A plan contract that provides excepted benefits as described in Section 2722 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-21).~~

~~(2) A plan contract that qualifies as a grandfathered health plan under Section 1251 of PPACA.~~

~~(g) This section shall be implemented only to the extent that federal law or policy does not require the state to defray the costs of benefits included within the definition of essential health benefits under this section.~~

~~(h) For purposes of this section, the following definitions shall apply:~~

~~(1) "Habilitative services" means health care services that help a person keep, learn, or improve skills and functioning for daily living.~~

~~(2) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.~~

~~(3) "Small group health care service plan contract" means a group health care service plan contract issued to a small employer, as defined in Section 1357.~~

~~SEC. 3. Section 10112.27 is added to the Insurance Code, to read:~~

~~10112.27. (a) An individual or small group health insurance policy issued, amended, or renewed on or after January 1, 2014, shall, at a minimum, include coverage for essential health benefits. For purposes of this section, "essential health benefits" means all of the following:~~

~~(1) (A) The benefits and services covered by the Kaiser Small Group HMO plan contract (product number 40513CA035) as this contract was offered during the first quarter of 2012, including, but not limited to, all of the following:~~

~~(i) The items and services covered by the plan contract within the categories identified in subsection (b) of Section 1302 of PPACA, including, but not limited to, ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric vision care.~~

~~(ii) Mandated benefits pursuant to statutes enacted before December 31, 2011.~~

~~(B) The services and benefits described in this paragraph shall be covered to the extent they are medically necessary. Scope and duration limits imposed on the services and benefits described in this paragraph shall be no greater than the scope and duration limits imposed on those services and benefits by the health care service plan contract identified in subparagraph (A).~~

~~(2) With respect to habilitative services, in addition to any habilitative services identified in paragraph (1), the same services as the policy covers for rehabilitative services. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the policy.~~

~~(3) With respect to pediatric oral care and pediatric vision care, the same services and benefits for pediatric oral care and pediatric vision care covered under the Federal Employees Dental and Vision Insurance Program dental plan and vision plan with the largest national enrollment as of the first quarter of 2012. Scope and duration limits imposed on the services and benefits described in this paragraph shall be no greater than the scope and duration limitations imposed on those benefits by the Federal Employees~~

~~Dental and Vision Insurance Program dental plan and vision plan with the largest national enrollment as of the first quarter of 2012.~~

~~(4) Any other benefits required to be covered under this part.~~

~~(b) When offering, issuing, selling, or marketing a health insurance policy, a health insurer shall not indicate or imply that the policy covers essential health benefits unless the policy covers essential health benefits as defined in this section.~~

~~(c) This section shall apply regardless of whether the policy is offered inside or outside the California Health Benefit Exchange created by Section 100500 of the Government Code.~~

~~(d) A health insurance policy subject to this section shall also comply with Section 10112.1.~~

~~(e) This section shall not be construed to prohibit a policy from covering additional benefits, including, but not limited to, spiritual care services that are tax deductible under Section 213 of the Internal Revenue Code.~~

~~(f) Subdivision (a) shall not apply to any of the following:~~

~~(1) A policy that provides excepted benefits as described in Section 2722 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-21).~~

~~(2) A health insurance policy that qualifies as a grandfathered health plan under Section 1251 of PPACA.~~

~~(g) This section shall be implemented only to the extent that federal law or policy does not require the state to defray the costs of benefits included within the definition of essential health benefits under this section.~~

~~(h) For purposes of this section, the following definitions shall apply:~~

~~(1) "Habilitative services" means health care services that help a person keep, learn, or improve skills and functioning for daily living.~~

~~(2) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.~~

~~(3) "Small group health insurance policy" means a group health insurance policy issued to a small employer, as defined in Section 10700.~~

~~SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.~~

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